SB0725/137572/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 725
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, after "Pharmacies" insert "and Pharmacists"; strike beginning with "enter" in line 3 down through "contracts" in line 5 and substitute "disclose certain information to a pharmacy or a pharmacist at the time of entering into a contract with the pharmacy or pharmacist and at a certain time before a contract change"; in line 6, strike "or pharmacy claims" and substitute ", pharmacists, and claims of pharmacies and pharmacists"; in the same line, after the semicolon insert "making certain provisions of law applicable to pharmacy benefits managers; requiring a pharmacy benefits manager to establish a certain appeals process; requiring a pharmacy benefits manager to establish a certain process for review of a failure to pay the contractual reimbursement amount of certain claims; making certain provisions of law applicable to health maintenance organizations; providing for the application of this Act;"; in line 7, strike "providing certain penalties;" and substitute "providing that this Act may not be construed to limit the applicability of certain provisions of law under certain circumstances;"; in line 8, after "pharmacies" insert "and pharmacists"; in line 11, after "15–1601" insert "through 15–1603"; and after line 14, insert:

"BY adding to
Article – Health – General
Section 19–706(ppp)
Annotated Code of Maryland
(2005 Replacement Volume and 2007 Supplement)".

AMENDMENT NO. 2

On pages 1 through 4, strike in their entirety the lines beginning with line 20 on page 1 through line 22 on page 4, inclusive, and substitute:

(Over)

"**(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.**

(B) "BENEFICIARY" MEANS AN INDIVIDUAL WHO RECEIVES PRESCRIPTION DRUG COVERAGE OR BENEFITS FROM A PURCHASER.

(C) "ERISA" HAS THE MEANING STATED IN § 8–301 OF THIS ARTICLE.

(D) "NONPROFIT HEALTH MAINTENANCE ORGANIZATION" HAS THE MEANING STATED IN § 6–121(A) OF THIS ARTICLE.

(E) "PHARMACIST" HAS THE MEANING STATED IN § 12-101 OF THE HEALTH OCCUPATIONS ARTICLE.

(F) "PHARMACY" HAS THE MEANING STATED IN § 12-101 OF THE HEALTH OCCUPATIONS ARTICLE.

(G) (1) "PHARMACY BENEFITS MANAGEMENT SERVICES" MEANS:

(I) THE PROCUREMENT OF PRESCRIPTION DRUGS AT A NEGOTIATED RATE FOR DISPENSATION WITHIN THE STATE TO BENEFICIARIES;

(II) THE ADMINISTRATION OR MANAGEMENT OF PRESCRIPTION DRUG COVERAGE PROVIDED BY A PURCHASER FOR BENEFICIARIES; AND

(III) ANY OF THE FOLLOWING SERVICES PROVIDED WITH REGARD TO THE ADMINISTRATION OF PRESCRIPTION DRUG COVERAGE:

1. MAIL SERVICE PHARMACY;

2. CLAIMS PROCESSING, RETAIL NETWORK MANAGEMENT, AND PAYMENT OF CLAIMS TO PHARMACIES FOR PRESCRIPTION DRUGS DISPENSED TO BENEFICIARIES;

3. CLINICAL FORMULARY DEVELOPMENT AND MANAGEMENT SERVICES;

4. REBATE CONTRACTING AND ADMINISTRATION;

5. PATIENT COMPLIANCE, THERAPEUTIC INTERVENTION, AND GENERIC SUBSTITUTION PROGRAMS; OR

6. DISEASE MANAGEMENT PROGRAMS.

(2) "PHARMACY BENEFITS MANAGEMENT SERVICES" DOES NOT INCLUDE ANY SERVICE PROVIDED BY A NONPROFIT HEALTH MAINTENANCE ORGANIZATION THAT OPERATES AS A GROUP MODEL, PROVIDED THAT THE SERVICE:

(I) IS PROVIDED SOLELY TO A MEMBER OF THE NONPROFIT HEALTH MAINTENANCE ORGANIZATION; AND

(II) IS FURNISHED THROUGH THE INTERNAL PHARMACY OPERATIONS OF THE NONPROFIT HEALTH MAINTENANCE ORGANIZATION.

(H) "PHARMACY BENEFITS MANAGER" MEANS A PERSON THAT PERFORMS PHARMACY BENEFITS MANAGEMENT SERVICES.

(I) (1) "PURCHASER" MEANS THE STATE EMPLOYEE AND RETIREE HEALTH AND WELFARE BENEFITS PROGRAM, AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION THAT:

(I) PROVIDES PRESCRIPTION DRUG COVERAGE OR BENEFITS IN THE STATE; AND

(II) ENTERS INTO AN AGREEMENT WITH A PHARMACY BENEFITS MANAGER FOR THE PROVISION OF PHARMACY BENEFITS MANAGEMENT SERVICES.

(2) "PURCHASER" DOES NOT INCLUDE A PERSON THAT PROVIDES PRESCRIPTION DRUG COVERAGE OR BENEFITS THROUGH PLANS SUBJECT TO ERISA AND THAT DOES NOT PROVIDE PRESCRIPTION DRUG COVERAGE OR BENEFITS THROUGH INSURANCE, UNLESS THE PERSON IS A MULTIPLE EMPLOYER WELFARE ARRANGEMENT AS DEFINED IN § 514(B)(6)(A)(II) OF ERISA.

15–1602.

AT THE TIME OF ENTERING INTO A CONTRACT WITH A PHARMACY OR A PHARMACIST, AND AT LEAST 30 WORKING DAYS BEFORE ANY CONTRACT CHANGE, A PHARMACY BENEFITS MANAGER SHALL DISCLOSE TO THE PHARMACY OR PHARMACIST:

(1) THE APPLICABLE TERMS, CONDITIONS, AND REIMBURSEMENT RATES;

(2) THE PROCESS AND PROCEDURES FOR VERIFYING PHARMACY BENEFITS AND BENEFICIARY ELIGIBILITY;

(3) THE DISPUTE RESOLUTION AND AUDIT APPEALS PROCESS; AND

(4) THE PROCESS AND PROCEDURES FOR VERIFYING THE PRESCRIPTION DRUGS INCLUDED ON THE FORMULARIES USED BY THE PHARMACY BENEFITS MANAGER.

15–1603.

(A) THIS SECTION DOES NOT APPLY TO AN AUDIT THAT INVOLVES PROBABLE OR POTENTIAL FRAUD OR WILLFUL MISREPRESENTATION BY A PHARMACY OR PHARMACIST.

(B) A PHARMACY BENEFITS MANAGER SHALL CONDUCT AN AUDIT OF A PHARMACY OR PHARMACIST UNDER CONTRACT WITH THE PHARMACY BENEFITS MANAGER IN ACCORDANCE WITH THIS SECTION.

(C) A PHARMACY BENEFITS MANAGER MAY NOT SCHEDULE AN ONSITE AUDIT TO BEGIN DURING THE FIRST 5 CALENDAR DAYS OF A MONTH UNLESS REQUESTED BY THE PHARMACY OR PHARMACIST.

(D) WHEN CONDUCTING AN AUDIT, A PHARMACY BENEFITS MANAGER SHALL:

(1) IF THE AUDIT IS ONSITE, PROVIDE WRITTEN NOTICE TO THE PHARMACY OR PHARMACIST AT LEAST 2 WEEKS BEFORE CONDUCTING THE INITIAL ONSITE AUDIT FOR EACH AUDIT CYCLE;

(2) EMPLOY THE SERVICES OF A PHARMACIST IF THE AUDIT REQUIRES THE CLINICAL OR PROFESSIONAL JUDGMENT OF A PHARMACIST;

(3) FOR PURPOSES OF VALIDATING THE PHARMACY RECORD WITH RESPECT TO ORDERS OR REFILLS OF A DRUG THAT IS A CONTROLLED DANGEROUS SUBSTANCE, ALLOW THE PHARMACY OR PHARMACIST TO USE HOSPITAL OR PHYSICIAN RECORDS THAT ARE:

(I) WRITTEN; OR

(II) TRANSMITTED ELECTRONICALLY;

(4) AUDIT EACH PHARMACY AND PHARMACIST UNDER THE SAME STANDARDS AND PARAMETERS AS OTHER SIMILARLY SITUATED PHARMACIES OR PHARMACISTS AUDITED BY THE PHARMACY BENEFITS MANAGER;

(5) ONLY AUDIT CLAIMS SUBMITTED OR ADJUDICATED WITHIN THE 2-YEAR PERIOD IMMEDIATELY PRECEDING THE AUDIT, UNLESS A LONGER PERIOD IS PERMITTED UNDER FEDERAL OR STATE LAW;

(6) DELIVER THE PRELIMINARY AUDIT REPORT TO THE PHARMACY OR PHARMACIST WITHIN 120 CALENDAR DAYS AFTER THE COMPLETION OF THE AUDIT, WITH REASONABLE EXTENSIONS ALLOWED;

(7) IN ACCORDANCE WITH SUBSECTION (G) OF THIS SECTION, ALLOW A PHARMACY OR PHARMACIST TO PRODUCE DOCUMENTATION TO ADDRESS ANY DISCREPANCY FOUND DURING THE AUDIT; AND

(8) DELIVER THE FINAL AUDIT REPORT TO THE PHARMACY OR PHARMACIST:

(I) WITHIN 6 MONTHS AFTER DELIVERY OF THE PRELIMINARY AUDIT REPORT IF THE PHARMACY OR PHARMACIST DOES NOT REQUEST AN INTERNAL APPEAL UNDER SUBSECTION (G) OF THIS SECTION; OR

(II) WITHIN 30 DAYS AFTER THE CONCLUSION OF THE INTERNAL APPEALS PROCESS UNDER SUBSECTION (G) OF THIS SECTION IF THE PHARMACY OR PHARMACIST REQUESTS AN INTERNAL APPEAL.

(E) A PHARMACY BENEFITS MANAGER MAY NOT USE THE ACCOUNTING PRACTICE OF EXTRAPOLATION TO CALCULATE OVERPAYMENTS OR UNDERPAYMENTS.

(F) THE RECOUPMENT OF A CLAIMS PAYMENT FROM A PHARMACY OR PHARMACIST BY A PHARMACY BENEFITS MANAGER SHALL BE BASED ON AN ACTUAL OVERPAYMENT OR DENIAL OF AN AUDITED CLAIM UNLESS THE PROJECTED OVERPAYMENT OR DENIAL IS PART OF A SETTLEMENT AGREED TO BY THE PHARMACY OR PHARMACIST.

(G) (1) A PHARMACY BENEFITS MANAGER SHALL ESTABLISH AN INTERNAL APPEALS PROCESS UNDER WHICH A PHARMACY OR PHARMACIST MAY APPEAL ANY DISPUTED CLAIM IN A PRELIMINARY AUDIT REPORT.

(2) UNDER THE INTERNAL APPEALS PROCESS, A PHARMACY BENEFITS MANAGER SHALL ALLOW A PHARMACY OR PHARMACIST TO REQUEST AN INTERNAL APPEAL WITHIN 30 WORKING DAYS AFTER RECEIPT OF THE PRELIMINARY AUDIT REPORT, WITH REASONABLE EXTENSIONS ALLOWED.

(3) THE PHARMACY BENEFITS MANAGER SHALL INCLUDE IN ITS PRELIMINARY AUDIT REPORT A WRITTEN EXPLANATION OF THE INTERNAL

APPEALS PROCESS, INCLUDING THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON TO WHOM AN INTERNAL APPEAL SHOULD BE ADDRESSED.

(4) THE DECISION OF THE PHARMACY BENEFITS MANAGER ON AN APPEAL OF A DISPUTED CLAIM IN A PRELIMINARY AUDIT REPORT BY A PHARMACY OR PHARMACIST SHALL BE REFLECTED IN THE FINAL AUDIT REPORT.

(5) THE PHARMACY BENEFITS MANAGER SHALL DELIVER THE FINAL AUDIT REPORT TO THE PHARMACY OR PHARMACIST WITHIN 30 CALENDAR DAYS AFTER CONCLUSION OF THE INTERNAL APPEALS PROCESS.

(H) (1) A PHARMACY BENEFITS MANAGER MAY NOT RECOUP BY SETOFF ANY MONEYS FOR AN OVERPAYMENT OR DENIAL OF A CLAIM UNTIL 30 WORKING DAYS AFTER THE DATE THE FINAL AUDIT REPORT HAS BEEN PROVIDED TO THE PHARMACY OR PHARMACIST.

(2) A PHARMACY BENEFITS MANAGER SHALL REMIT ANY MONEY DUE TO A PHARMACY OR PHARMACIST AS A RESULT OF AN UNDERPAYMENT OF A CLAIM WITHIN 30 WORKING DAYS AFTER THE FINAL AUDIT REPORT HAS BEEN DELIVERED TO THE PHARMACY OR PHARMACIST.

(3) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (1) OF THIS SUBSECTION, A PHARMACY BENEFITS MANAGER MAY WITHHOLD FUTURE PAYMENTS BEFORE THE DATE THE FINAL AUDIT REPORT HAS BEEN PROVIDED TO THE PHARMACY OR PHARMACIST IF THE IDENTIFIED DISCREPANCY FOR ALL DISPUTED CLAIMS IN A PRELIMINARY AUDIT REPORT FOR AN INDIVIDUAL AUDIT EXCEEDS $25,000.

(I) (1) A PHARMACY BENEFITS MANAGER SHALL ESTABLISH A REASONABLE INTERNAL REVIEW PROCESS FOR A PHARMACY TO REQUEST THE REVIEW OF A FAILURE TO PAY THE CONTRACTUAL REIMBURSEMENT AMOUNT OF A SUBMITTED CLAIM.

(2) A PHARMACY MAY REQUEST A PHARMACY BENEFITS MANAGER TO REVIEW A FAILURE TO PAY THE CONTRACTUAL REIMBURSEMENT AMOUNT OF A CLAIM WITHIN 180 CALENDAR DAYS AFTER THE DATE THE SUBMITTED CLAIM WAS PAID BY THE PHARMACY BENEFITS MANAGER.

(3) THE PHARMACY BENEFITS MANAGER SHALL GIVE WRITTEN NOTICE OF ITS REVIEW DECISION WITHIN 90 CALENDAR DAYS AFTER RECEIPT OF A REQUEST FOR REVIEW FROM A PHARMACY UNDER THIS SUBSECTION.

(4) IF THE PHARMACY BENEFITS MANAGER DETERMINES THROUGH THE INTERNAL REVIEW PROCESS ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION THAT THE PHARMACY BENEFITS MANAGER UNDERPAID A PHARMACY, THE PHARMACY BENEFITS MANAGER SHALL PAY ANY MONEY DUE TO THE PHARMACY WITHIN 30 WORKING DAYS AFTER COMPLETION OF THE INTERNAL REVIEW PROCESS.

(5) THIS SUBSECTION MAY NOT BE CONSTRUED TO LIMIT THE ABILITY OF A PHARMACY AND A PHARMACY BENEFITS MANAGER TO CONTRACTUALLY AGREE THAT A PHARMACY MAY HAVE MORE THAN 180 CALENDAR DAYS TO REQUEST AN INTERNAL REVIEW OF A FAILURE OF THE PHARMACY BENEFITS MANAGER TO PAY THE CONTRACTUAL AMOUNT OF A SUBMITTED CLAIM.

(J) ON REQUEST OF THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE, A PHARMACY BENEFITS MANAGER SHALL PROVIDE A COPY OF ITS AUDIT PROCEDURES OR APPEALS PROCESS.

Article – Health – General

19–706.

(PPP) THE PROVISIONS OF TITLE 15, SUBTITLE 16 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

SECTION 2. AND BE IT FURTHER ENACTED, That the provisions of § 15-1602 of the Insurance Article, as enacted by Section 1 of this Act, shall apply to contracts entered into or renewed between a pharmacist or pharmacy and a pharmacy benefits manager on or after January 1, 2009.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall apply to audits conducted by pharmacy benefits managers on or after January 1, 2009.

SECTION 4. AND BE IT FURTHER ENACTED, That nothing in this Act shall be construed to limit the applicability of §§ 15-1008, 15-1009(b), 27-303(2), 27-304(4), and 27-304(15) of the Insurance Article to claim denials made by or on behalf of an insurer, nonprofit health service plan, dental plan organization, or health maintenance organization.";

and in line 23, strike "2." and substitute "5.".